Mount Sinai-Irving J. Selikoff Center for Occupational & Environmental Medicine
Respirator Medical Evaluation Questionnaire

To the employee: Can you read (check one): □ Yes □ No
If a translator is required, what language: _____
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator. Please print.

Today's date: _____ Interviewer: _____

1. Your name: _____ Last 4 digits of your SS #_____

2. Your Age (to nearest year): _____ Date of Birth:_____

3. Street Address:_____ City:_____

State:_____ Zip Code:_____ County:_____

4. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): (_____) _____
The best time to phone you at this number:_____

5. Ethnicity (optional - circle one): (1) White (Non-Hispanic), (2) African American, (3) Hispanic, (4) Native American, (5) Other _____

6. Sex (check one): □ Male □ Female

7. Your Height: _____ ft. _____ in. 8. Your Weight: _____ lbs.

9. Your Job Title:_____ 10. Union: _____

11. Employer:_____ 12. Work Site: _____

13. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): □ Yes □ No

14. Check the type of respirator you will use (you can check more than one category):
a._____ N, R, or P disposable respirator (filter mask, non-cartridge type only)
b._____ Other (for example, _____Half or _____Full-facepiece type, _____Powered air purifying, _____Supplied air, _____Self-contained breathing apparatus)

15. Have you worn a respirator: □ Yes □ No
If "yes," what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

1. a. Have you ever smoked tobacco? (If no continue to question 2) □ Yes □ No
   If **yes**, at what age did you begin? _____
   b. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month? □ Yes □ No
   If **no**, how long ago did you quit? _____ Age at that time:_____
   Average number of cigarettes per day when you did smoke:_____
   c. Present average number of cigarettes per day: _____

2. Have you *ever had* any of the following conditions?
   a. Seizures (fits): □ Yes □ No
   b. Diabetes (sugar disease): □ Yes □ No
   c. Allergic reactions that interfere with your breathing: □ Yes □ No
   d. Claustrophobia (fear of closed-in places): □ Yes □ No
   e. Trouble smelling odors: □ Yes □ No
   f. History of facial burns, serious skin problems on your face, or other facial deformities? □ Yes □ No
   g. Other conditions that may interfere with respirator use or result in limited work ability: □ Yes □ No

3. Have you *ever had* any of the following pulmonary or lung problems?
   a. Asbestosis: □ Yes □ No
   b. Asthma: □ Yes □ No
   c. Chronic bronchitis: □ Yes □ No
   d. Emphysema: □ Yes □ No
   e. Pneumonia: □ Yes □ No
   f. Tuberculosis: □ Yes □ No
   g. Silicosis: □ Yes □ No
   h. Pneumothorax (collapsed lung): □ Yes □ No
   i. Lung cancer: □ Yes □ No
   j. Broken ribs: □ Yes □ No
   k. Any chest injuries or surgeries: □ Yes □ No
   l. History of sinusitis or severe rhinitis (colds): □ Yes □ No
   m. Any other lung problem that you've been told about: □ Yes □ No

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: □ Yes □ No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: □ Yes □ No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: □ Yes □ No
   d. Have to stop for breath when walking at your own pace on level ground: □ Yes □ No
   e. Shortness of breath when washing or dressing yourself: □ Yes □ No
   f. Shortness of breath that interferes with your job: □ Yes □ No

g. Coughing that produces phlegm (thick sputum): □ Yes □ No
h. Coughing that wakes you early in the morning: □ Yes □ No
i. Coughing that occurs mostly when you are lying down: □ Yes □ No
j. Coughing up blood in the last month: □ Yes □ No
k. Wheezing: □ Yes □ No
l. Wheezing that interferes with your job: □ Yes □ No
m. Chest pain when you breathe deeply: □ Yes □ No
n. Any other symptoms that may be related to lung problems: □ Yes □ No

5. Have you *ever had* any of the following cardiovascular or heart problems?
a. Heart attack: □ Yes □ No
b. Stroke: □ Yes □ No
c. Angina: □ Yes □ No
d. Heart failure: □ Yes □ No
e. Swelling in your legs or feet (not caused by walking): □ Yes □ No
f. Heart arrhythmia (heart beating irregularly): □ Yes □ No
g. High blood pressure: □ Yes □ No
h. Any other heart problem that you've been told about: □ Yes □ No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?
a. Frequent pain or tightness in your chest: □ Yes □ No
b. Pain or tightness in your chest during physical activity: □ Yes □ No
c. Pain or tightness in your chest that interferes with your job: □ Yes □ No
d. In the past two years, have you noticed your heart skipping or missing a beat: □ Yes □ No
e. Heartburn or indigestion that is not related to eating: □ Yes □ No
f. Any other symptoms that you think may be related to heart or circulation problems: □ Yes □ No

7. Do you *currently* take medication for any of the following problems?
a. Breathing or lung problems: □ Yes □ No
b. Heart trouble: □ Yes □ No
c. Blood pressure: □ Yes □ No
d. Seizures (fits): □ Yes □ No
Are you taking any other medications, including over-the-counter? □ Yes □ No
If yes, please list _____

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9) □
a. Eye irritation: □ Yes □ No
b. Skin allergies or rashes: □ Yes □ No
c. Anxiety: □ Yes □ No
d. General weakness or fatigue: □ Yes □ No
e. Any other problem that interferes with your use of a respirator: □ Yes □ No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: □ Yes □ No

Questions 10 to 17 below must be answered by every employee who has been selected to use either a <u>full-facepiece respirator or a self-contained breathing apparatus (SCBA).</u> For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost* vision in either eye (temporarily or permanently): □ Yes □ No

11. Do you *currently* have any of the following vision problems?
    a. Wear contact lenses: □ Yes □ No
    b. Wear glasses: □ Yes □ No
    c. Color blind: □ Yes □ No
    d. Any other eye or vision problem: □ Yes □ No

12. Have you *ever had* an injury to your ears, including a broken eardrum: □ Yes □ No

13. Do you *currently* have any of the following hearing problems?
    a. Difficulty hearing: □ Yes □ No
    b. Wear a hearing aid: □ Yes □ No
    c. Any other hearing or ear problem: □ Yes □ No

14. Have you *ever had* a back injury: □ Yes □ No

15. Do you *currently* have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs, or feet: □ Yes □ No
    b. Back pain: □ Yes □ No
    c. Difficulty fully moving your arms and legs: □ Yes □ No
    d. Pain or stiffness when you lean forward or backward at the waist: □ Yes □ No
    e. Difficulty fully moving your head up or down: □ Yes □ No
    f. Difficulty fully moving your head side to side: □ Yes □ No
    g. Difficulty bending at your knees: □ Yes □ No
    h. Difficulty squatting to the ground: □ Yes □ No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: □ Yes □ No
    j. Any other muscle or skeletal problem that interferes with using a respirator: □ Yes □ No

16. Have you ever had a chest x-ray? □ Yes □ No
    If yes, what is the date of your last chest x-ray?_____
    To the best of you knowledge, were any abnormalities found? □ Yes □ No
    If yes, please describe:_____

17. Have you ever had a breathing test? □ Yes □ No
    If yes, what is the date of your last test?_____
    To the best of you knowledge, were any abnormalities found? □ Yes □ No
    If yes, please describe:_____

Part B: Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. Describe the work you'll be doing while you're using your respirator:

_____

_____

2. Will you be using any of the following items with your respirator?

a. HEPA Filters (pink, red): □ Yes □ No

b. Canisters (for example, gas masks): □ Yes □ No

c. Cartridges: □ Yes □ No

3. How often are you expected to use the respirator (check "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): □ Yes □ No

b. Emergency rescue only: □ Yes □ No

c. Less than 5 hours *per week:* □ Yes □ No

d. Less than 2 hours *per day:* □ Yes □ No

e. 2 to 4 hours *per day*: □ Yes □ No

f. Over 4 hours *per day*: □ Yes □ No

4. During the period you are using the respirator, is your work effort:

a. *Light*: [e.g., sitting while typing or writing; performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.]

□ Yes □ No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

b. *Moderate*: [e.g., sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, or assembling a moderate load (about 35 lbs.) at trunk level; walking; pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.]

□ Yes □ No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

c. *Heavy*: [e.g., lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).]

□ Yes □ No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

5. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: □ Yes □ No
If "yes," describe this protective clothing and/or equipment:_____
_____

6. Describe any special or hazardous conditions you might encounter when you're using your respirator (e.g., confined spaces, life-threatening gases):
_____
_____

7. List the hazardous substances that you work with while wearing a respirator:_____
_____
_____

8. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others (e.g. rescue, security):
_____
_____

9. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos:	□ Yes □ No	b. Silica (e.g., in sandblasting):	□ Yes □ No
c. Beryllium:	□ Yes □ No	d. Tungsten/cobalt:	□ Yes □ No
e. Aluminum:	□ Yes □ No	f. Coal (for example, mining):	□ Yes □ No
g. Iron:	□ Yes □ No	h. Dusty environments:	□ Yes □ No
i. Tin:	□ Yes □ No	j. Solvents (e.g., paints, lacquers)	□ Yes □ No

k. Any other hazardous exposures: □ Yes □ No

If "yes," describe these exposures:_____
_____
_____

10. At home have you been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or had skin contact with hazardous chemicals: □ Yes □ No
If "yes," name the chemicals if you know them: _____
_____

11. List any second jobs or side businesses you have: _____
_____

12. Have you been in the military services? □ Yes □ No
If "yes," were you exposed to biological or chemical agents (either in training or combat): □ Yes □ No

13. Have you ever worked on a HAZMAT team? □ Yes □ No

Please mail the Completed Questionnaire to: Norman Zuckerman, C/o Mount Sinai, 345 East 102nd St - Suite 401, N.Y., N.Y. 10029